

## GENERAL DENTAL RADIOGRAPHIC EQUIPMENT DATA FORMS

<b>MEDICAL/DENTAL X-RAY EQUIPMENT DATA</b> NAVMED 6470/4 (7-80)		REPORT SYMBOL MED 6470-15																																		
<b>1. FACILITY IDENTIFICATION</b>																																				
a. FACILITY NAME		b. UIC																																		
c. MAILING ADDRESS		d. BUILDING	e. ROOM																																	
<b>2. STATUS OF THE EQUIPMENT</b> (INDICATE IF EQUIPMENT IS IN USE OR THE REASON FOR NOT BEING IN USE). <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> IN USE  <input type="checkbox"/> NOT IN USE         </div> <div> <input type="checkbox"/> TO BE REPAIRED  <input type="checkbox"/> CANNOT BE REPAIRED         </div> <div> <input type="checkbox"/> STORED IN GOOD WORKING CONDITION  <input type="checkbox"/> OTHER         </div> </div>																																				
<b>3. X-RAY EQUIPMENT IDENTIFICATION</b>  <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">           a. PLANT ACCOUNT NUMBER            b. YEAR EQUIPMENT WAS MANUFACTURED            c. INSTALLATION DATE OF EQUIPMENT            d. X-RAY EQUIPMENT IS CERTIFIED: YES ____ NO ____         </div> <div style="width: 50%; text-align: center;"> <table border="1" style="margin: auto;"> <tr><td style="height: 20px; width: 50px;"></td></tr> <tr><td style="height: 20px; width: 50px;"></td></tr> <tr><td style="height: 20px; width: 50px;"></td></tr> </table> </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;">           e. COMPONENT            1) CONTROL CONSOLE            2) X-RAY TABLE            3) X-RAY TUBE ASSEMBLY                TUBE #1 HOUSING                TUBE #1 INSERT                TUBE #1 COLLIMATOR             IMAGE INTENSIFIER         </div> <div style="width: 65%;"> <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th style="width: 30%;">f. MANUFACTURER</th> <th style="width: 30%;">g. MODEL</th> <th style="width: 40%;">h. SERIAL NUMBER</th> </tr> </thead> <tbody> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> </tbody> </table> </div> </div> <div style="text-align: right; padding-top: 10px;"> <input type="checkbox"/> CONTINUED ON SEPARATE SHEET       </div>							f. MANUFACTURER	g. MODEL	h. SERIAL NUMBER																											
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<b>4. TYPE OF X-RAY EQUIPMENT (CHECK AS MANY AS APPROPRIATE)</b> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> RADIOGRAPHIC  <input type="checkbox"/> FLUOROSCOPIC  <input type="checkbox"/> COMBINATION R/F         </div> <div> <input type="checkbox"/> FIXED  <input type="checkbox"/> MOBILE  <input type="checkbox"/> OTHER _____         </div> <div> <input type="checkbox"/> DENTAL INTRAORAL  <input type="checkbox"/> DENTAL PANORAPHIC         </div> </div>																																				
<b>5. GENERATOR (CHECK ONE)</b> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> AUTORECTIFIED  <input type="checkbox"/> SINGLE PHASE HALF WAVE  <input type="checkbox"/> SINGLE PHASE FULL WAVE         </div> <div> <input type="checkbox"/> THREE PHASE  <input type="checkbox"/> CAPACITOR DISCHARGE  <input type="checkbox"/> OTHER (SPECIFY) _____         </div> <div>           MAXIMUM mA ____ mA             MAXIMUM kVp ____ kVp         </div> </div>																																				
<b>6. ASSOCIATED EQUIPMENT (CHECK AS MANY AS APPROPRIATE)</b> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> AUTOMATIC EXPOSURE CONTROL SYSTEM (LIKE PHOTOTIMER)  <input type="checkbox"/> SPOT FILM DEVICE         </div> <div> <input type="checkbox"/> OTHER _____         </div> <div> <input type="checkbox"/> PHOTOSPOT CAMERA  <input type="checkbox"/> IMAGE INTENSIFIER         </div> </div>																																				
<b>7. USE (CHECK ONE)</b> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> GENERAL RADIOGRAPHY  <input type="checkbox"/> CHEST RADIOGRAPHY  <input type="checkbox"/> HEAD RADIOGRAPHY         </div> <div> <input type="checkbox"/> MAMMOGRAPHY  <input type="checkbox"/> TOMOGRAPHY  <input type="checkbox"/> UROLOGY STUDIES         </div> <div> <input type="checkbox"/> OTHER (SPECIFY) _____            _____         </div> </div>																																				
<b>8. DATE OF LAST RADIATION PROTECTION SURVEY</b>  DATE: <input type="checkbox"/> UNKNOWN		<b>9. THIS EQUIPMENT REPLACED EQUIPMENT WITH PLANT ACCOUNT NUMBER.</b>  <input type="checkbox"/> UNKNOWN																																		
<b>10. REPORTED BY:</b>  TITLE:		<b>REVIEWED BY:</b>  DATE:																																		

GENERAL REQUIREMENTS FOR RADIOGRAPHIC EQUIPMENT			
NAVMED 6470/5 (12-89)		REPORT SYMBOL MED 6470-10	
<b>1. FACILITY IDENTIFICATION</b>			
a. FACILITY NAME	b. UIC		
c. MAILING ADDRESS	d. BUILDING	e. ROOM	
<b>2. RADIATION SAFETY EQUIPMENT AND ACCESSORIES</b>			
EQUIPMENT OR ACCESSORY	YES	NO	COMMENTS
a. APRONS:      ADEQUATE NUMBER	<input type="checkbox"/>	<input type="checkbox"/>	
GOOD CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	
b. GLOVES:      ADEQUATE NUMBER	<input type="checkbox"/>	<input type="checkbox"/>	
GOOD CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	
c. GONADAL SHIELDS	<input type="checkbox"/>	<input type="checkbox"/>	
TYPE: Lead Rubber Shield			
d. ADEQUATE PATIENT IMMOBILIZATION EQUIPMENT	<input type="checkbox"/>	<input type="checkbox"/>	
e. WARNING LABELS PRESENT AT CONTROL PANEL (CERTIFIED EQUIPMENT REQUIREMENT)	<input type="checkbox"/>	<input type="checkbox"/>	
f. LIGHTS, METERS IN GOOD WORKING CONDITION.	<input type="checkbox"/>	<input type="checkbox"/>	
g. INTERLOCKS ARE SATISFACTORY.	<input type="checkbox"/>	<input type="checkbox"/>	
h. MECHANICAL/ELECTRICAL STOPS IN GOOD CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	
i. CABLES AND GROUPING IN GOOD CONDITION.	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3. GENERAL CHARACTERISTICS AND PERFORMANCE REQUIREMENTS.</b>			
EQUIPMENT OR ACCESSORY	YES	NO	COMMENTS
a. MEANS TO CENTER X-RAY SOURCE OVER IMAGE RECEPTOR IS AVAILABLE (FIXED EQUIPMENT)	<input type="checkbox"/>	<input type="checkbox"/>	
b. TECHNIQUE FACTORS INDICATED BEFORE EXPOSURE.	<input type="checkbox"/>	<input type="checkbox"/>	
c. TECHNIQUE FACTORS VISIBLE AT OPERATOR'S POSITION.	<input type="checkbox"/>	<input type="checkbox"/>	
d. EXPOSURE TERMINATED AFTER:	<input type="checkbox"/>	<input type="checkbox"/>	
PRESET:      TIME <input type="checkbox"/> mAs <input type="checkbox"/>			
NO. OF PULSES    OR <input type="checkbox"/>			
RADIATION EXPOSURE TO IMAGE RECEPTOR. <input type="checkbox"/>			
e. EXPOSURE SWITCH AT ADEQUATE LOCATION.	<input type="checkbox"/>	<input type="checkbox"/>	
f. EXPOSURE SWITCH REQUIRES CONTINUOUS PRESSURE TO OPERATE.	<input type="checkbox"/>	<input type="checkbox"/>	
g. EXPOSURE NOT POSSIBLE WITH THE TIMER IN AN OFF OR ZERO POSITION.	<input type="checkbox"/>	<input type="checkbox"/>	
h. VARIABLE COLLIMATION DEVICES ARE PROVIDED WITH LIGHT FIELDS.	<input type="checkbox"/>	<input type="checkbox"/>	

GENERAL REQUIREMENTS FOR RADIOGRAPHIC EQUIPMENT (CON'T)		REPORT SYMBOL MED 6470-10
3. GENERAL CHARACTERISTICS AND PERFORMANCE REQUIREMENTS. (CONT)		
EQUIPMENT OR ACCESSORY	YES	NO
i. AUDIBLE INDICATION OF EXPOSURE TERMINATION.	<input type="checkbox"/>	<input type="checkbox"/>
j. VISIBLE "BEAM ON" INDICATION.	<input type="checkbox"/>	<input type="checkbox"/>
k. MEANS TO INDICATE WHEN BEAM AXIS IS PERPENDICULAR TO THE IMAGE RECEPTOR.	<input type="checkbox"/>	<input type="checkbox"/>
l. MEANS OF STEPLESS ADJUSTMENT OF X-RAY FIELD SIZE.	<input type="checkbox"/>	<input type="checkbox"/>
m. BEAM LIMITING DEVICE NUMERICALLY INDICATES FIELD SIZE.	<input type="checkbox"/>	<input type="checkbox"/>
n. POSITIVE BEAM LIMITING DEVICE (PBL) IN OPERATING CONDITION.	<input type="checkbox"/>	<input type="checkbox"/>
o. PBL MODE: ADJUSTMENT POSSIBLE TO FIELDS SMALLER THAN IMAGE RECEPTOR. *	<input type="checkbox"/>	<input type="checkbox"/>
p. AUTOMATIC RETURN TO PBL WHEN IMAGE RECEPTOR IS CHANGED. *	<input type="checkbox"/>	<input type="checkbox"/>
q. X-RAY PRODUCTION PREVENTED AT SID'S WHERE OPERATION IS NOT INTENDED.	<input type="checkbox"/>	<input type="checkbox"/>
*GENERAL PURPOSE X-RAY EQUIPMENT		
4. MOBILE X-RAY EQUIPMENT		
EXPOSURE SWITCH IS LOCATED SO THAT OPERATOR CAN STAND AT LEAST 6 FEET FROM PATIENT AND USEFUL BEAM.		
YES _____ NO _____		
5. CHARTS AVAILABLE AND POSTED.		
TECHNIQUE CHARTS	YES _____	NO _____
RATING CHARTS	YES _____	NO _____
6. REMARKS		
SURVEYOR:	DATE:	

GENERAL REQUIREMENTS FOR RADIOGRAPHIC/DENTAL EQUIPMENT					REPORT SYMBOL MED 6470-10																																																												
NAVMED 6470/6 (10-99)																																																																	
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<b>II. X-RAY EQUIPMENT IDENTIFICATION</b>																																																																	
1. X-RAY TUBE HOUSING:																																																																	
a. MODEL:		b. SERIAL NO.		c. CERTIFIED: YES ____ NO ____																																																													
<b>III. RADIATION EXPOSURE MEASUREMENTS</b>																																																																	
1. RADIATION EXPOSURE AND TIMER REPRODUCIBILITY.																																																																	
a. kVp	b. mA	c. Time	d. Distance SID: _____ TDD: _____																																																														
e. MEASUREMENTS																																																																	
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3. LINEARITY OF X-RAY OUTPUT																																																																	
a. kVp	b. Time	SID	TDD																																																														
LINEARITY OF mA/mAS			OUTPUT LINEARITY TRACKING BY KVP																																																														
mA	mRad	mR/mAs	X1-X2	0.1(X1+X2)	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th>kVp</th> <th>mA</th> <th>Time</th> <th>mRad</th> <th>mR/mAs</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	kVp	mA	Time	mRad	mR/mAs																																																							
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					R value <span style="border: 1px solid black; display: inline-block; width: 50px; height: 15px; vertical-align: middle;"></span>																																																												
4. INSTRUMENT USED:																																																																	
a. TYPE	b. MODEL	c. SERIAL NUMBER	d. CALIBRATION DATE																																																														
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GENERAL REQUIREMENTS FOR RADIOGRAPHIC/DENTAL EQUIPMENT (CON'T)

NAVMED 6470/6 (10-99)

REPORT SYMBOL MED 6470-10

5. KILOVOTAGE ACCURACY

a. kVp SETTING

1)	60 kVp
2)	80 kVp
3)	100 kVp
4)	120 kVp
5)	

b. kVp DETERMINED

kVp
kVp
kVp
kVp
kVp

c. ACCURACY


d. kV CHECKING DEVICE USED:

1) TYPE:

2) MODEL:

3) SERIAL NUMBER:

6. BEAM QUALITY

a. kVp

b. mA

c. Time

d. Distance

OTHER

f. MEASUREMENTS

ADDED FILTRATION
mmAl
mmAl
mmAl
mmAl
mmAl
mmAl

EXPOSURE
mR
mR
mR
mR
mR
mR

g. HVL

mmAl

EQUIVALENT

h. EQUIPMENT COMPLIES WITH HVL

REQUIREMENTS:

YES \_\_\_\_\_ NO \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

CERTIFIED EQUIPMENT: HVL SHALL NOT BE LESS THAN VALUES LISTED IN TABLE 1

SECTION 1020.30 OF TITLE 21, CHAPTER 1 CFR PART 1020.

OTHER EQUIPMENT: HVL SHOULD BE AS RECOMMENDED IN SECTION 3.2.1.

OF NCRP REPORT 33.

REMARKS

<b>REQUIREMENTS FOR DENTAL EQUIPMENT</b>	
NAVMED 6470/6 (10-99)	REPORT SYMBOL MED 6470-10
<b>IV. OTHER MEASUREMENTS</b>	
<b>1. INTRAORAL SYSTEMS</b>	
a. CONE LENGTH:	<input style="width: 80px; height: 15px;" type="text"/>
(SHOULD BE AT LEAST 18 cm (7 INCHES) FOR UNITS OPERATING ABOVE 50 kVp AND AT LEAST 10 cm (4 INCHES) FOR UNITS OPERATING BELOW 50 kVp).	
b. MINIMUM TARGET TO SKIN DISTANCE:	<input style="width: 80px; height: 15px;" type="text"/>
c. BEAM DIAMETER AT END OF CONE:	<input style="width: 80px; height: 15px;" type="text"/>
<b>2. DENTAL PANORAMIC UNITS</b>	
a. SLIT OPENING IS ALIGNED WITH OPENING IN FILM HOLDER:	
YES	<input style="width: 80px; height: 15px;" type="text"/>
NO	<input style="width: 80px; height: 15px;" type="text"/>
REMARKS	
SURVEYOR:	DATE: